An Analysis and Evaluation of Certificate of Need Regulation in Maryland

Working Paper: Inpatient Acute Care Hospital Services

Medical/Surgical and Pediatric Services

MARYLAND HEALTH CARE COMMISSION
Division of Health Resources
4201 Patterson Avenue
Baltimore, Maryland 21215
www.mhcc.state.md.us

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Donald E. Wilson, M.D., MACP
Chairman

Barbara Gill McLean
Interim Executive Director

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I. INTRODUCTION

A. Purpose of the Working Paper

With the 1999 passage of House Bill 995[1], the General Assembly required the Maryland Health Care Commission to examine the major policy issues of the Certificate of Need process, and to submit an interim report by January 1, 2001[2], followed by a final report by January 1, 2002. The Commission embarked upon a two-year process during which it would develop a series of working papers examining specific issues and implications of changes to the CON model of regulation. Acute care hospital services, including medicine, surgery, gynecology, addictions, and pediatric services are medical services defined in Commission statute, at Health-General Article 19-123(a), as requiring a Certificate of Need to establish and, in some cases, to expand once established. This report examines the current policy and regulatory issues affecting inpatient acute care hospital services, including medical-surgical and pediatric services,[3] and outlines several alternative options for changes to the Certificate of Need program and their potential implications.

B. Invitation for Public Comment

The Commission invites all interested organizations and individuals to submit comments on the options presented in this working paper. Written comments should be submitted no later than ***Monday, August 20, 2000*** to:

Barbara Gill McLean, Interim Executive Director
Maryland Health Care Commission
4201 Patterson Avenue; 5th Floor
Baltimore, MD 21215-2299
Fax: 410-358-1311
e-mail: bmclean@mhcc.state.md.us

C. Organization of the Working Paper

This paper is organized in four major sections. Following this introduction, Part II of the paper contains an overview of acute care hospital services in Maryland and provides both an inventory of existing providers and data on overall and service-specific utilization trends. Part III describes the functions of the state government agencies with regard to their authority over acute care hospital services, and Part IV describes how other states with Certificate of Need programs regulate acute care hospital services. Part V of the paper outlines alternative regulatory strategies for the State – continuing, changing, or discontinuing Certificate of Need regulation of these services— that reflect different assumptions about the role and ability of government, and of the market for health care services, to rationally allocate a crucial service and to protect the public interest.

[1] Chapter 702, Acts of 1999.
[2] *An Analysis and Evaluation of Certificate of Need Regulation in Maryland: Phase 1 Report to the General Assembly*, available on the Commission's website, www.mhcc.state.md.us.
[3] The policy and regulatory issues affecting acute inpatient obstetric services were examined in the Commission's Phase I Report to the General Assembly.

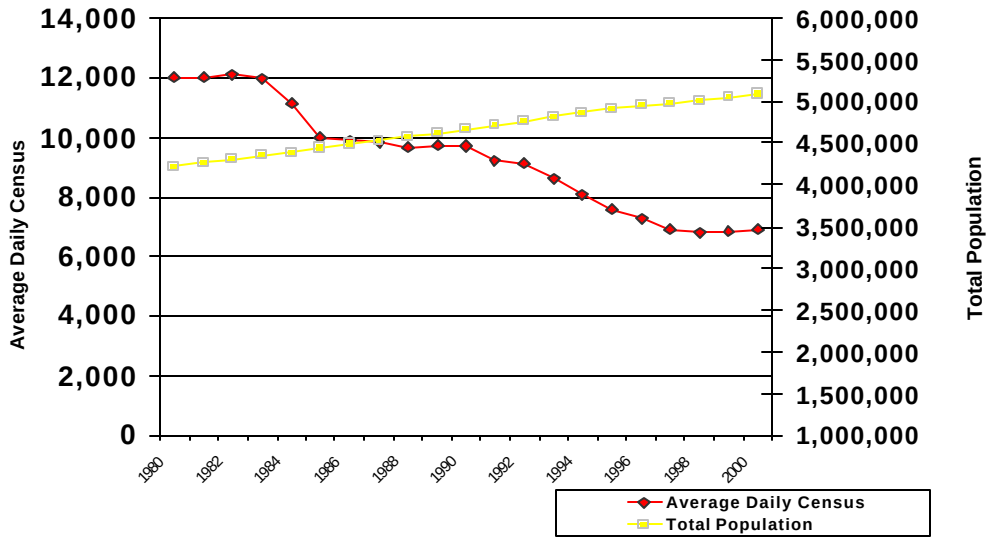
II. INPATIENT ACUTE CARE HOSPITAL SERVICES: OVERVIEW

A. Maryland Acute Care Hospital Services

1. Acute Care Hospital Utilization Trends: 1980-2000

In 2000, there were about 5,000 fewer patients using Maryland hospitals on an average day as compared to 1980 (Refer to Figure 1). Over this twenty-year period, the annual volume of acute care hospital patient days fell from almost 4.4 million to 2.5 million—a decrease of 42.6 percent (Refer to Table 1). Maryland's hospital patient day use rate fell from 1,041 to 760 per 1,000 persons between 1980 and 1990—an overall decrease of 27.0 percent. The use rate continued falling throughout the 1990's reaching a low of 493 patient days per 1,000 in 1999 before increasing slightly to 495 in 2000. These significant declines in inpatient utilization have occurred despite moderate growth in statewide population over the past two decades. The total population of Maryland increased by 20.6 percent between 1980 and 2000.

Figure 1
Acute Care Hospital Average Daily Census and Population Growth: Maryland, 1980-2000



Source: Maryland Health Care Commission (Data reported on hospital utilization is from the Hospital Discharge Abstract Data Base for calendar years 1980-2000; population data is based on data from the Maryland Departm ent of Planning, Population Estimates and Projections, Revised February 2000.)

One of the most important changes in the use of hospitals has been the movement toward shorter inpatient stays. The overall average stay for an acute care hospital patient in Maryland was 8.32 days in 1980. By 2000, the average length of stay fell by almost one-half to 4.43 days. While length of stay has been declining for some time, this trend has accelerated over the past ten years. Between 1980 and 1990, hospital average length of stay fell by an average of 2.3 percent annually. More recent data (1980-1990) show hospital stays declining by 3.0 percent annually.

Table 1
Trends in Acute Care Hospital Beds and Utilization: Maryland, 1980-2000

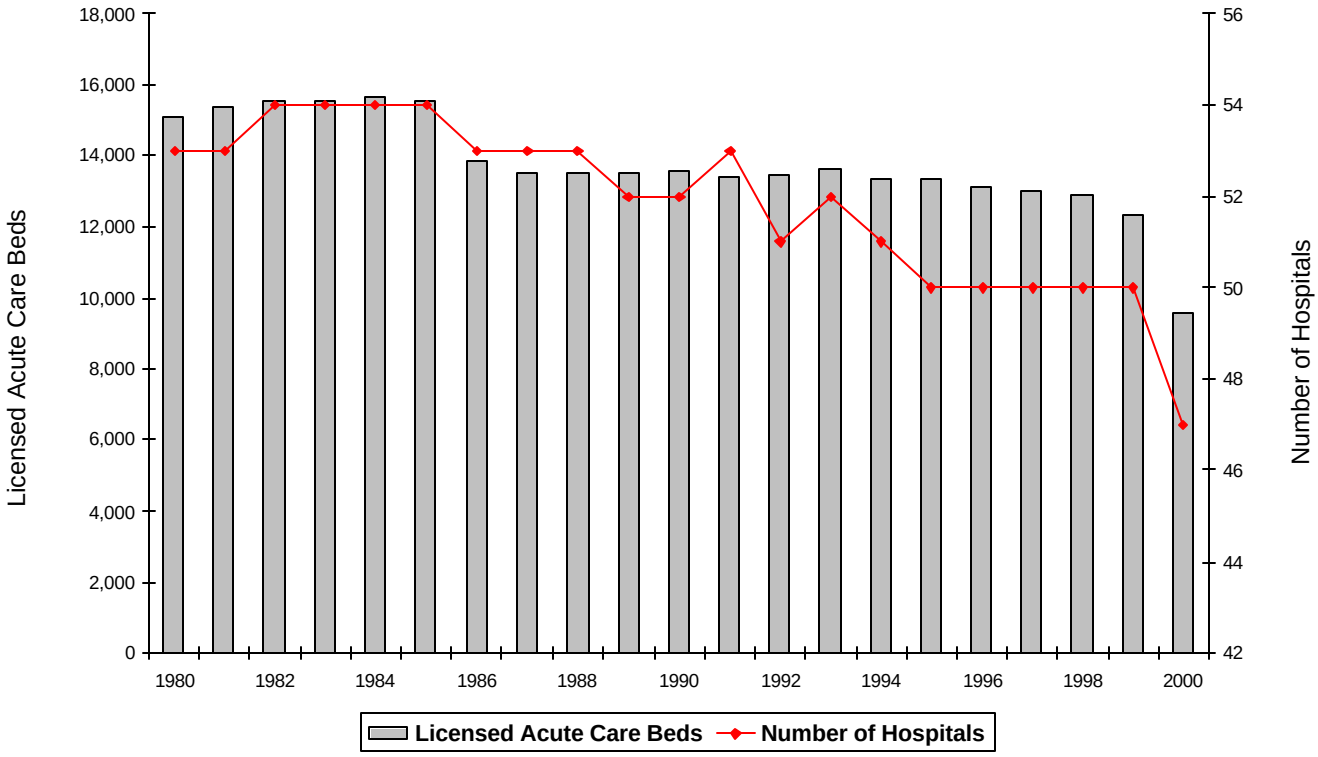
Year	Number of Acute Care Hospitals	Licensed Acute Care Beds	Total Population	Total Discharges	Total Patient Days	Average Length of Stay	Average Daily Census	Discharges Per 1,000 Population	Patient Days Per 1,000 Population
1980	53	15,082	4,216,975	527,545	4,388,984	8.32	11,992	125.10	1,040.79
1981	53	15,419	4,261,967	538,093	4,387,983	8.15	12,022	126.25	1,029.57
1982	54	15,506	4,306,959	558,001	4,419,814	7.92	12,109	129.56	1,026.20
1983	54	15,568	4,351,951	569,456	4,364,509	7.66	11,958	130.85	1,002.89
1984	54	15,639	4,396,943	569,598	4,063,725	7.13	11,103	129.54	924.22
1985	54	15,575	4,441,935	535,486	3,645,423	6.81	9,987	120.55	820.68
1986	53	13,872	4,486,927	526,583	3,602,410	6.84	9,870	117.36	802.87
1987	53	13,519	4,531,919	523,971	3,580,329	6.83	9,809	115.62	790.02
1988	53	13,505	4,576,911	535,377	3,527,158	6.59	9,637	116.97	770.64
1989	52	13,540	4,621,903	543,781	3,557,716	6.54	9,747	117.65	769.75
1990	52	13,570	4,666,897	555,081	3,547,355	6.39	9,719	118.94	760.11
1991	53	13,404	4,714,992	555,498	3,365,345	6.06	9,220	117.82	713.75
1992	51	13,439	4,763,087	556,418	3,327,500	5.98	9,092	116.82	698.60
1993	52	13,594	4,811,181	548,858	3,145,863	5.73	8,619	114.08	653.87
1994	51	13,357	4,863,201	552,480	2,940,650	5.32	8,057	113.60	604.67
1995	50	13,320	4,912,277	552,562	2,768,258	5.01	7,584	112.49	563.54
1996	50	13,136	4,947,038	547,886	2,649,938	4.84	7,240	110.75	535.66
1997	50	13,019	4,981,799	538,757	2,519,140	4.68	6,902	108.15	505.67
1998	50	12,902	5,016,560	542,261	2,481,879	4.58	6,800	108.09	494.74
1999	50	12,328	5,051,321	553,455	2,492,218	4.50	6,828	109.57	493.38
2000	47	9,562	5,086,082	568,361	2,517,965	4.43	6,880	111.75	495.07

Source: Maryland Health Care Commission (Data reported on hospital utilization is from the Hospital Discharge Abstract Data Base for calendar years 1980-2000; population data reported is based on data from the Maryland Department of Planning, Population Estimates and Projections, Revised February 2000; and data on licensed acute care beds is from MHCC inventory files.)

2. Hospital Bed Capacity Trends

The total number of licensed acute care hospital beds peaked in 1984 and has declined steadily since that time (Refer to Table 1 and Figure 2). In 1984, the 54 operating acute care hospitals in Maryland were licensed for a total of 15,639 beds. Following implementation of Medicare's prospective payment system in 1983, which resulted in sharp drops in hospital occupancy in Maryland and nationally, the number of licensed beds fell between 1984-1986 by 11.3 percent (1,767 beds). After remaining fairly stable throughout the 1990s, the number of beds fell sharply once again following implementation of a new approach to licensing hospitals enacted during the 1999 session of the General Assembly. As of 2000, the 47 acute care hospitals operating in Maryland were licensed for a total of 9,562 beds.

Figure 2
Acute Care Hospitals and Licensed Beds:
Maryland, 1980-2000



Source: Maryland Health Care Commission (Data reported on licensed acute care hospitals and beds are from Commission inventory files)

Over the past two decades, eight acute care hospitals licensed for 1,217 beds have closed in Maryland. As shown in Table 2, six of the eight hospitals that have closed were located in Baltimore City.

Table 2
Acute Care Hospital Closures: Maryland, 1986-2001

Hospital Closed/Jurisdiction	Date	Licensed Beds	Hospital System Affiliation
Lutheran Hospital *(Baltimore City)*	1986	197	Liberty Medical Center
Wyman Park Hospital *(Baltimore City)*	1986	135	Johns Hopkins Health System
North Charles Hospital *(Baltimore City)*	1991	248	Johns Hopkins Health System
Leland Memorial Hospital *(Prince George's Co.)*	1993	120	Adventist Healthcare
Frostburg Community Hospital *(Allegany Co.)*	1995	37	Western Maryland Health System
Liberty Medical Center *(Baltimore City)*	1999	282	Bon Secours Baltimore Health System
Children's Hospital *(Baltimore City)*	1999	54	LifeBridge
Church Hospital *(Baltimore City)*	1999	144	MedStar Health
TOTAL		**1,217**	

Source: Maryland Health Care Commission

HB 994, the Hospital Capacity and Cost Containment Act, has emerged as a significant factor in the future supply and distribution of inpatient beds in acute general hospitals. Under this legislation, there is an annual recalculation of hospital licensed bed capacity, which requires a yearly adjustment to the number of licensed beds each acute general hospital is permitted to maintain during the next fiscal year. The Commission works with the Office of Health Care Quality to determine the overall bed capacity each hospital will have for the next year, based on applying a factor of 140 percent of the average daily census from the last twelve months of complete occupancy data to the hospital's current bed capacity.[4] Given the next year's capacity figure, each hospital may, if it chooses, reallocate the number of beds among its existing medical services, according to previous experience or projected changes in utilization.[5] This provision of HB 994 took effect on July 1, 2000, and was first implemented in October of that year. The number of pediatric beds in Maryland decreased at a higher percentage (21.16%) than medical-surgical beds (7.63%) when this new licensure system was implemented.

[4] As Commission Staff described in the "fact sheet" presented to the Commission on October 25, 2000 and subsequently posted on the MHCC website, the implementation of this provision is a cooperative effort: the Health Services Cost Review Commission provides the data on which the annual calculation is based; the MHCC reviews and approves each hospital's designation of the new bed total by existing medical services and maintains a Hospital Inventory Database; and OHCQ issues the revised license total, as a letter to be attached to each hospital's current license, since the actual license is only issued once every three years, to coincide with the survey and re-accreditation by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO).

[5] This reallocation is permitted through an existing provision in Commission statute, originally enacted in 1988 and further clarified in regulation, that permits increases or decreases in the bed complement of an existing medical service in an acute general hospital, as long as the total bed capacity does not increase, "and the change is maintained for at least one year" unless modified by the approval of a Certificate of Need (or for a merged system, an exemption from Certificate of Need), or by a change made during the annual calculation itself. §19-123 (h)(2)(ii), COMAR 10.24.01.02A(3)(b).

3. Development of Merged Asset Hospital Systems in Maryland

Consolidation and merger activity in the healthcare industry is proceeding at a rapid pace in Maryland and across the nation. Table 3 shows the nine merged hospital systems currently operating in Maryland. These systems, defined as multiple-hospital systems under common management and governance, now include one-half (23) of the 47 licensed acute care hospitals in Maryland. The three largest merged asset hospital systems (Johns Hopkins Health System, MedStar Health, and University of Maryland Medical System) account for one-third of total licensed acute care beds in Maryland as of July 1, 2001.

Incentives to encourage the merger and consolidation of acute care hospitals in Maryland originated from the 1985 Health Care Cost Containment Act-Hospital Mergers and Consolidations. Prior to 1985, there were only two hospital systems operating in Maryland (Adventist Healthcare and Dimensions Healthcare System). Following enactment of the Health Care Cost Containment legislation, merger activity resulted in the formation of Liberty Medical Center (1986), and the Johns Hopkins Health System (1986). In 1987, initial steps to form Helix Health System, predecessor to MedStar, and the Upper Chesapeake Health System occurred. After a brief hiatus, the pace of merger activity accelerated in the mid-1990s with the formation of LifeBridge Health, Shore Health System, and Western Maryland Health System.

While initial merger activity in Maryland involved principally the acquisition of one or more health care facilities by another organization, more recently there has been consolidation of merged asset systems. MedStar Health, for example, was formed in 1998 by the merger of two systems—Helix Health and Medlantic Healthcare. Another recent trend impacting the formation of hospital systems concerns the geographic location of facilities entering into merger agreements. While early merger activity in Maryland involved hospitals located in the same jurisdiction, more recent activity has focused on joining health care facilities located in different jurisdictions and, in one case, different states. Both of these trends, the further consolidation of merged asset systems and the merger of hospitals located in different jurisdictions, are likely to continue in the future given pressures to strengthen market share.

Table 3
Maryland Hospital Systems: 2001

Hospital System Name	Year Initially Formed	Licensed Beds 7/1/01	Current Acute Care Hospital Members *(Licensed Beds 7/1/01)*	Location of Acute Care Hospitals
Adventist Healthcare	Prior to 1985	586	Washington Adventist Hospital *(338 Beds)* Shady Grove Adventist Hospital *(248 Beds)*	Montgomery County
Dimensions Healthcare System	Prior to 1985	391	Laurel Regional Hospital *(107 Beds)* Prince George's Hospital Center *(284 Beds)*	Prince George's County
Johns Hopkins Health System	1986	1,417	Johns Hopkins Hospital *(927 Beds)* Bayview Medical Center *(311 Beds)* Howard County Hospital *(179 Beds)*	Baltimore City Howard County
LifeBridge	1998	549	Sinai Hospital of Baltimore *(368 Beds)* Northwest Hospital *(181 Beds)*	Baltimore City Baltimore County
MedStar Health (1)	1998	2,325	Franklin Square Hospital *(329 Beds)* Union Memorial Hospital *(250 Beds)* Good Samaritan Hospital *(204 Beds)* Harbor Hospital *(170 Beds)* Washington Hospital Center *(837 Beds)* Georgetown University Hospital *(535 Beds)*	Baltimore City Baltimore County Washington, D.C.
Shore Health System	1996	206	Dorchester General Hospital *(68 Beds)* Memorial Hospital of Easton *(138 Beds)*	Dorchester County Talbot County
Western Maryland Health System	1996	259	Sacred Heart Hospital *(132 Beds)* Memorial Hospital of Cumberland *(127 Beds)*	Allegany County
University of Maryland Medical System (2)	1992	1,050	University of Maryland Hospital *(629 Beds)* James L. Kernan Hospital *(8 Beds)* Maryland General Hospital *(183 Beds)* North Arundel Hospital *(230 Beds)*	Baltimore City Anne Arundel County
Upper Chesapeake Health System	1986	250	Harford Memorial Hospital *(99 Beds)* Upper Chesapeake Medical Center *(151 Beds)*	Harford County
TOTAL (3)		**7,033**		

Notes:

(1) MedStar Health was formed in 1998 by the merger of Helix Health and Medlantic Healthcare. Helix Health was formed in 1987 by the merger of Franklin Square Hospital and Union Memorial Hospital. Subsequently, Good Samaritan, Church, and Harbor Hospitals joined Helix Health.

(2) The North Arundel Hospital merged with Mt. Washington Pediatric Hospital to form the North Arundel Health System in 1997. In 2000, the North Arundel Health System became a part of the University of Maryland Medical System.

(3) Of the total acute care beds in hospital systems, 5,661 beds are located in Maryland hospitals.

B. Medical-Surgical and Pediatric Services

1. Supply and Distribution of Medical-Surgical and Pediatric Services

For planning purposes, medical-surgical services include medicine, intensive and coronary care, surgery, gynecology, and addictions. Pediatric services refer to those services provided for the special health needs of patients less than 15 years of age that are not included in diagnostic categories defined as neonatal, obstetrical, rehabilitation, or psychiatric, usually in a specific unit, ward, wing, or hospital.

As of July 2000, there are 47 acute general hospitals in Maryland providing medical-surgical services. Of these hospitals, 33 have pediatric units. Table 4 shows these hospitals by jurisdiction and region, system membership, the number of licensed medical-surgical and pediatric beds at each.

Table 4
Medical-Surgical and Pediatric Services Inventory, System Affiliation, Beds and Discharges: Maryland, 2000

Jurisdiction/ Local Health Planning Area	Hospital	System Affiliation	Medical/Surgical		Pediatrics	
			Beds	Disch.	Beds	Disch.
Allegany	Memorial of Cumberland Hosp	Western Md Hlth System	117	6,518	13	530
	Sacred Heart Hospital	Western Md Hlth System	128	6,095	0	1
Carroll	Carroll Co. General Hospital		119	8,666	7	374
Frederick	Frederick Memorial Hospital		193	11,174	10	415
Garrett	Garrett Co. Memorial Hospital		29	2,306	2	126
Washington	Washington County Hospital		187	11,376	7	653
WESTERN MARYLAND TOTAL			**773**	**46,135**	**39**	**2,099**
Montgomery	Holy Cross Hospital		238	13,992	20	1,130
	Montgomery General Hospital		97	6,489	2	44
	Shady Grove Adventist Hospital	Adventist Hlth Care	169	9,494	25	1,384
	Suburban Hospital		187	11,073	6	148
	Washington Adventist Hospital	Adventist Hlth Care	271	11,119	0	15
MONTGOMERY COUNTY TOTAL			**962**	**52,167**	**53**	**2,721**
Calvert	Calvert Memorial Hospital		66	4,913	2	169
Charles	Civista Medical Center		77	4,991	5	302
Prince Georges	Doctor's Community Hospital		166	9,438	0	21
	Fort Washington Comm. Hosp.		36	2,150	0	0
	Laurel Regional Hospital	Dimensions Hlth System	81	4,810	0	14
	Prince George's Hospital Cntr	Dimensions Hlth System	201	9,634	8	443
	Southern Maryland Hosp Cntr		170	9,734	6	302
St. Mary's	St. Mary's Hospital		53	4,465	6	455
SOUTHERN MARYLAND TOTAL			**850**	**50,135**	**27**	**1,706**
Anne Arundel	Anne Arundel Medical Center		179	13,619	12	1,002
	North Arundel Hospital	Univ of Md Med System	207	13,851	10	306
Baltimore County	Franklin Square Hospital	MedStar Health	197	15,754	21	778
	GBMC		240	15,491	8	424
	Northwest Hospital Center	LifeBridge Health	171	10,653	0	22
	St. Joseph Hospital		236	15,284	10	335
Baltimore City	Bon Secours Hospital		114	5,831	0	3
	Good Samaritan Hospital	MedStar Health	196	10,709	0	3
	Harbor Hospital	MedStar Health	123	9,035	6	558
	Johns Hopkins Bayview	Johns Hopkins Health Sys.	250	15,960	10	257
	Johns Hopkins Hospital	Johns Hopkins Health Sys.	632	26,020	148	4,590
	Kernan Hospital	Univ of Md Med System	7	559	0	167
	Maryland General Hospital	Univ of Md Med System	106	6,890	0	35
	Mercy Medical Center		171	11,202	6	318
	Sinai Hospital of Baltimore	LifeBridge Health	276	15,596	27	1,392
	St. Agnes Hospital		240	15,130	13	771
	Union Memorial Hospital	MedStar Health	202	13,062	6	403
	University of Maryland	Univ of Md Med System	491	22,224	46	2,023
Harford	Harford Memorial Hospital	Upper Chesapeake Hlth Sys	92	5,289	0	295
	Upper Chesapeake Med. Cen.	Upper Chesapeake Hlth Sys	106	7,830	5	123
Howard	Howard Co. General Hospital	Johns Hopkins Health Sys.	117	8,004	4	523
CENTRAL MARYLAND TOTAL			**4,353**	**257,993**	**332**	**14,328**
Cecil	Union Hospital of Cecil		72	5,536	6	293
Dorchester	Dorchester General Hospital	Shore Health System	45	3,328	0	139
Kent	Kent & Queen Anne's Hospital		37	2,617	4	161
Somerset	McCready Memorial Hospital		13	1,039	0	26
Talbot	Memorial Hospital at Easton	Shore Health System	90	7,319	15	520
Wicomico	Peninsula Regional Med Cntr		252	14,355	12	598
Worcester	Atlantic General Hospital		37	2,494	0	18
EASTERN SHORE TOTAL			**546**	**36,688**	**37**	**1,755**
MARYLAND TOTAL			**7,484**	**443,118**	**488**	**22,609**

Source: Maryland Health Care Commission (Data reported on medical-surgical and pediatric discharges is from the Hospital Discharge Abstract Data Base for calendar year 2000; data on licensed acute care beds is from MHCC licensure files)

The 14 hospitals that currently do not operate a pediatric service are listed in Table 5. These hospitals are located throughout the state and include three in single-hospital jurisdictions on the lower Eastern Shore, four facilities in Baltimore City, one in Western Maryland, and six in suburban counties immediately surrounding Baltimore and Washington. Nine of the 14 hospitals that do not presently offer pediatric services are members of multi-hospital systems with pediatric services available at one or more other member institutions.

Table 5
Acute Care Hospitals Without Pediatric Services: Maryland, July 2000

Hospital Name	Jurisdiction	System Affiliation
Atlantic General Hospital	Worcester County	
Bon Secours Hospital	Baltimore City	
Doctors Community Hospital	Prince George's County	
Dorchester General Hospital	Dorchester County	Shore Health System
Fort Washington Community Hospital	Prince George's County	
Good Samaritan Hospital	Baltimore City	MedStar Health
Harford Memorial Hospital	Harford County	Upper Chesapeake Hlth
Kernan Hospital	Baltimore City	University of Maryland
Laurel Regional Hospital	Prince George's County	Dimensions Health System
Maryland General Hospital	Baltimore City	University of Maryland
McCready Memorial Hospital	Somerset County	
Northwest Hospital	Baltimore County	LifeBridge Health
Sacred Heart Hospital	Allegany County	Western Maryland Hlth Sys.
Washington Adventist Hospital	Montgomery County	Adventist Healthcare

Source: Maryland Health Care Commission

2. Trends in the Utilization of Medical-Surgical and Pediatric Services: 1995-2000

Medical-surgical service discharges generally have increased over the past several years, as shown in Table 6. In 1995, there were a total of 427,121 medical/surgical service discharges from Maryland hospitals. Data reported for 2000 indicates that the volume of medical-surgical service discharges increased to 446,505, a 4.5 percent increase over 1995. Average length of stay for hospital medical-surgical services declined between 1990 and 2000, from 5.43 to 4.68 days. The declining length of stay has offset the increased number of discharges during this period, resulting in a decline in patient days. Although there have been fluctuations, the average daily census (ADC) in Maryland medical-surgical units declined from 6,351 to 5,709 between 1995 and 2000.

Table 6
Trends in Medical-Surgical Patients by Region: Maryland, Selected Years, 1995 – 2000

Region	1995	1996	1997	1998	1999	2000
Medical-Surgical Discharges						
Western Maryland	44,738	44,148	43,426	43,696	44,384	46,135
Montgomery County	50,745	49,048	48,508	49,112	50,443	52,167
Southern Maryland	46,158	45,075	44,914	45,293	47,239	50,135
Central Maryland	254,081	254,872	249,350	250,873	247,460	261,377
Eastern Shore	31,399	31,142	32,305	34,049	35,174	36,691
Maryland	**427,121**	**424,285**	**418,503**	**422,023**	**424,700**	**446,505**
Average Length of Stay (in days)						
Western Maryland	5.45	5.11	4.85	4.65	4.75	4.45
Montgomery County	5.48	5.46	5.31	5.22	5.30	5.12
Southern Maryland	5.65	5.51	5.31	5.14	4.88	4.73
Central Maryland	5.40	5.12	4.91	4.78	4.66	4.63
Eastern Shore	5.23	4.99	4.62	4.42	4.41	4.45
Maryland	**5.43**	**5.19**	**4.97**	**4.83**	**4.75**	**4.68**
Average Daily Census						
Western Maryland	668	618	577	557	577	562
Montgomery County	762	734	706	702	732	732
Southern Maryland	715	681	654	638	632	650
Central Maryland	3,756	3,577	3,356	3,284	3,224	3,319
Eastern Shore	450	426	409	412	425	447
Maryland	**6,351**	**6,036**	**5,701**	**5,593**	**5,589**	**5,709**
Average Charge per Admission						
Western Maryland	$5,439	$5,680	$5,787	$5,892	$6,058	$5,969
Montgomery County	7,511	8,004	8,378	8,477	8,509	8,603
Southern Maryland	6,800	7,291	7,404	7,588	7,280	7,311
Central Maryland	8,130	8,530	8,850	9,357	9,484	9,593
Eastern Shore	5,820	5,928	6,054	6,246	6,545	6,553
Maryland	**$7,463**	**$7,853**	**$8,109**	**$8,461**	**$8,539**	**$8,597**

Source: Maryland Health Care Commission (Data reported on hospital utilization is from the Hospital Discharge Abstract Data Base for calendar years 1995-2000; data on average charge per admission is from the HSCRC Financial Data Base.)

Pediatric services experienced a decline in discharges from 28,464 in 1995 to 22,914 in 2000 (Refer to Table 7). Average length of stay fluctuated from 1995 to 2000, but showed an overall decline from 3.21 to 3.09 days. With declining discharges and average length of stay, average daily census fell from 243 to 194. Average charge per admission, however, increased from $4,782 to $5,560 indicating that hospitals may be treating more complicated pediatric admissions.

Table 7
Trends in Pediatric Patients by Planning Region: Maryland, Selected Years, 1995 – 2000

Pediatric Discharges						
Region	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**
Western Maryland	2,700	2,333	2,252	1,957	2,402	2,099
Montgomery County	2,511	2,804	2,974	2,573	2,996	2,721
Southern Maryland	2,391	2,094	1,886	1,750	2,062	1,530
Central Maryland	18,126	16,679	17,063	14,659	15,699	14,817
Eastern Shore	2,736	2,176	2,126	1,956	2,194	1,747
Maryland	**28,464**	**26,086**	**26,301**	**22,895**	**25,353**	**22,914**
Average Length of Stay (in days)						
Western Maryland	2.70	2.48	2.61	2.39	2.35	2.15
Montgomery County	2.24	2.30	2.43	2.49	2.34	2.29
Southern Maryland	2.44	2.35	2.33	2.15	2.09	2.56
Central Maryland	3.61	3.64	3.39	3.53	3.47	3.54
Eastern Shore	2.61	2.49	2.34	2.16	2.10	2.10
Maryland	**3.21**	**3.19**	**3.05**	**3.10**	**3.00**	**3.09**
Average Daily Census						
Western Maryland	20	16	16	13	15	12
Montgomery County	15	18	20	18	19	17
Southern Maryland	16	14	12	10	12	11
Central Maryland	172	160	152	136	140	144
Eastern Shore	20	15	14	12	13	10
Maryland Average	**243**	**222**	**213**	**188**	**200**	**194**
Average Charge per Admission						
Western Maryland	$2,351	$2,393	$2,375	$2,612	$2,625	$2,541
Montgomery County	2,596	3,201	3,819	3,596	3,480	3,411
Southern Maryland	2,755	2,964	3,094	2,622	2,755	2,766
Central Maryland	6,079	6,395	6,261	6,788	6,845	6,597
Eastern Shore	2,736	2,459	2,559	2,729	2,588	3,647
Maryland	**$4,782**	**$5,090**	**$5,126**	**$5,441**	**$5,344**	**$5,560**

Source: Maryland Health Care Commission (Data reported on hospital utilization is from the Hospital Discharge Abstract Data Base for calendar years 1995-2000; data on average charge per admission is from the HSCRC Financial Data Base.)

3. Charges for Medical-Surgical and Pediatric Services

The average charge per case for medical-surgical and pediatric admissions in Maryland in 2000 was $8,597. The average charge per hospital ranged from $17,998 at the University of Maryland Medical Center, to $4,616 at McCready Memorial Hospital. The average charge per admission in 2000 was less for pediatric patients at $5,560. The average hospital charge ranged from $1,957 at St. Mary's Hospital to $10,158 at the University of Maryland Medical Center.

On Table 8 the 2000 average charge for medical-surgical and pediatric services is displayed by payor source. The Medicaid Program has the highest average cost per admission at $10,425. Workers' Compensation and Medicare have the highest average cost for pediatric patients at $20,407 and $13,208. Managed care payors account for over 50 percent of all pediatric admissions to hospitals. For medical-surgical admissions, Medicare is the largest payer accounting for 50 percent of all admissions.

Table 8
Discharges, Total Charges, and Average Charge Per Case by Payor Source for Medical-Surgical and Pediatric Services: Maryland, 2000

Payor Source	Pediatric Service		
	Discharges	Total Charges	Average Charge
Blue Cross (Other State)	536	$4,821,926	$8,996
Blue Cross of Maryland	2,811	$14,382,365	$5,116
Blue Cross of the National Capital Area	269	$1,346,710	$5,006
Commercial Insurance/PPO	3,609	$22,489,106	$6,231
Managed Care Payer	6,193	$29,860,013	$4,822
Medicaid	1,973	$15,624,389	$7,919
Medicaid Managed Care	6,635	$33,626,875	$5,068
Medicare	25	$286,133	$11,445
Medicare Managed Care	57	$756,962	$13,280
Other	21	$153,395	$7,305
Other Government Program	333	$1,373,767	$4,125
Self Pay	576	$2,416,751	$4,196
Title V	3	$14,747	$4,916
Unknown	25	$142,398	$5,696
Workers' Compensation	15	$306,111	$20,407
MARYLAND TOTAL	23,081	$127,601,650	$5,528

Payor Source	Medical-Surgical Service		
	Discharge	Total Charge	Average Charge
Blue Cross (Other State)	5,981	$59,763,725	$9,992
Blue Cross of Maryland	36,769	$291,748,508	$7,935
Blue Cross of the National Capital Area	4,403	$38,724,913	$8,795
Charity - No Charge	570	$2,968,507	$5,208
Commercial Insurance/PPO	40,862	$343,889,389	$8,416
Donor	90	$250,008	$2,778
Managed Care Payer	70,774	$551,383,884	$7,791
Medicaid	18,099	$189,230,187	$10,455
Medicaid Managed Care	21,621	$173,538,850	$8,026
Medicare	199,946	$1,847,179,396	$9,238
Medicare Managed Care	17,248	$154,766,039	$8,973
Other	874	$7,376,113	$8,439
Other Government Program	3,110	$21,730,883	$6,987
Self Pay	21,884	$122,140,157	$5,581
Unknown	761	$4,457,669	$5,858
Workers' Compensation	4,168	$37,013,082	$8,880
MARYLAND TOTAL	447,160	$3,844,234,520	$8,597

Source: Maryland Health Care Commission (Data reported on discharges and charges is from the Hospital Discharge Abstract Data Base, Calendar Year 2000)

4. Medical-Surgical and Pediatric Bed Need Projections: 2000

Under Maryland health planning law, the establishment of a new medical-surgical or pediatric service requires Certificate of Need approval. To guide the development of all acute care services, including medical-surgical and pediatrics, the State Health Plan (SHP) contains planning policies, a need projection, and criteria and standards for reviewing CON applications.

Need for medical/surgical and pediatric services are projected on a jurisdictional rather than a regional or statewide basis, because these services are considered basic hospital services. The current SHP projections, which reflect a base year of 1994 and target year of 2000, show an overall statewide excess of medical-surgical and pediatric beds. In the upcoming months, the Commission will update this need forecast to reflect more current utilization data, and the implementation of regulations changing licensure procedures for acute care beds under HB 994.

Geographic access to acute care hospital services (medical-surgical services) and pediatric services, as measured by travel time, is displayed in Tables 9-10. As shown in Table 9, 95 percent of Maryland residents 15 years of age and older are within 30 minutes, one-way driving time of at least one acute care hospital; 80 percent of the population have access to two acute care hospitals within 30 minutes driving time. For pediatric services, 94 percent of Maryland residents under 15 years of age are within 30 minutes, one-way driving time of at least one pediatric service; 73 percent of the population in this age group have access within 30 minutes to two hospitals offering pediatric services.

Table 9

Geographic Access to Medical- Surgical Services: Maryland Residents (2000)

Number of Hospitals/ Travel Time	Total MD Population 15 Yrs. and Over	MD Population 15 Yrs. and Over W/in Travel Time	% of Population w/in Travel Time
One Hospital			
30 Minutes		3,858,693	94.87%
60 Minutes		4,030,067	99.08%
90 Minutes		4,035,086	99.21%
120 Minutes		4,042,373	99.38%
	4,067,392		
Two Hospitals			
30 Minutes		3,255,026	80.03%
60 Minutes		3,993,607	98.19%
90 Minutes		4,031,944	99.13%
120 Minutes		4,037,523	99.27%
	4,067,392		
Three Hospitals			
30 Minutes		2,863,018	70.39%
60 Minutes		3,779,418	92.92%
90 Minutes		4,016,820	98.76%
120 Minutes		4,037,312	99.26%
	4,067,392		
More Than Three Hospitals			
30 Minutes		2,572,513	63.25%
60 Minutes		3,490,678	85.82%
90 Minutes		3,893,174	95.72%
120 Minutes		3,982,820	97.92%
	4,067,392		

Provided by Spatial Insights Inc. 05/21/2001

Source: Applied Geographic Solutions, Inc. Estimates and Projections 2000

Table 10

Geographic Access to Pediatrics Services: Maryland Residents (2000)

Number of Hospitals/ Travel Time	Total MD Population 0-14 Yrs.	MD Population 0-14 Yrs. W/in Travel Time	% of Population w/in Travel Time
One Hospital			
30 Minutes		1,074,443	93.71%
60 Minutes		1,135,068	99.00%
90 Minutes		1,137,057	99.17%
120 Minutes		1,139,593	99.39%
	1,146,591		
Two Hospitals			
30 Minutes		833,233	72.67%
60 Minutes		1,075,983	93.84%
90 Minutes		1,114,036	97.16%
120 Minutes		1,133,904	98.89%
	1,146,591		
Three Hospitals			
30 Minutes		687,507	59.96%
60 Minutes		1,020,921	89.04%
90 Minutes		1,081,451	94.32%
120 Minutes		1,097,427	95.71%
	1,146,591		
More Than Three Hospitals			
30 Minutes		588,408	51.32%
60 Minutes		971,436	84.72%
90 Minutes		1,057,640	92.24%
120 Minutes		1,087,036	94.81%
	1,146,591		

Provided by Spatial Insights Inc. 05/21/2001

Source: Applied Geographic Solutions, Inc. Estimates and Projections 2000

III. GOVERNMENT OVERSIGHT OF INPATIENT ACUTE CARE HOSPITAL SERVICES IN MARYLAND

Government oversight of acute care hospital (medical-surgical and pediatrics services, including facilities, staff and program operation) is principally the responsibility of seven agencies: the Department of Health and Mental Hygiene, the Board of Physician Quality Assurance, the Board of Nursing, the Maryland Institute for Emergency Medical Services Systems, the Maryland Insurance Administration, the Health Services Cost Review Commission, and the Maryland Health Care Commission (MHCC). Although this report focuses on the oversight responsibilities of the MHCC, it is important to consider how medical/surgical and pediatric services are regulated by other agencies of State government.

A. Department of Health and Mental Hygiene (DHMH)

The Department of Health and Mental Hygiene (DHMH) develops and administers public health programs, for the purpose of protecting and promoting the health of Maryland residents. A complex organization with a broad scope of responsibility, DHMH is comprised of over 30 program administrations, 24 local health departments, over 20 residential facilities, and more than 20 health professional boards and commissions. Three administrations within DHMH work closely together in overseeing the operation of and reimbursement for inpatient hospital services.

The Office of Health Care Quality (OHCQ), an administration within DHMH, is responsible for overseeing the quality of care and compliance with both state and federal regulations in all hospitals and health-related institutions in Maryland. OHCQ licenses these facilities or, for hospitals accredited by the Joint Commission on Accreditation of Healthcare Organizations, OHCQ 'deems' them to meet state licensure standards. It also investigates quality of care complaints from the general public and those referred by the state's insurance commissioner. OHCQ is also responsible for licensing birthing centers.

B. Board of Physician Quality Assurance and Board of Nursing

Health occupation regulatory boards associated with DHMH oversee the licensure of health professionals in Maryland. The Board of Physician Quality Assurance (BPQA) will accept and investigate complaints it receives regarding physicians.

C. Maryland Institute for Emergency Medical Services Systems

The Maryland Institute for Emergency Medical Services Systems adopts standards for designation of trauma and specialty centers. Designation is the process by which a hospital is identified by the Emergency Medical Services board as an appropriate facility to receive particular referrals, such as high-risk medical/surgical and pediatrics or trauma cases. Application for designation as a specialty referral center is voluntary. On a five-level system of care, only levels III, III+ and IV are designated to receive referrals of high-risk medical-surgical and pediatrics cases and have a neonatal intensive care unit. The centers are surveyed at established intervals to maintain their designation.

D. Maryland Insurance Administration

The Maryland Insurance Administration (MIA) regulates the practice and the financial performance of health insurers, third party administrators, and "private review agents," who perform utilization review as well as prior authorization of health services for insurers. It establishes requirements both for rate-making and disclosure and for fair trade practices. The MIA also handles consumer complaints regarding coverage decisions and appeals of medical necessity decisions made by HMOs and other health insurers.

The Maryland Insurance Administration assumed responsibility for qualifying and regulating the "private review agents" empowered to act as third-party utilization review entities in managing behavioral health care in the State. This authority had been originally given to the Office of Health Care Quality, and was transferred from the licensing statute (at §19-1301, *et seq*, of the Health-General Article) to become Subtitle 10B,Title 15 of the Insurance Article, Annotated Code of Maryland.[6]

E. Health Services Cost Review Commission (HSCRC)

The Health Services Cost Review Commission is empowered by State law to set the rates that all acute general, private psychiatric hospitals and specialty hospitals may charge for inpatient services. HSCRC initially establishes a hospital's rates through the application of a rate review methodology, which uses a peer group evaluation to determine the reasonableness of a hospital's projected expenses. Adjustments are then made to reflect the individual hospital's uncompensated care and payer mix. Once a hospital's rates are established, the hospital will usually receive annual increases to its rates for inflation.

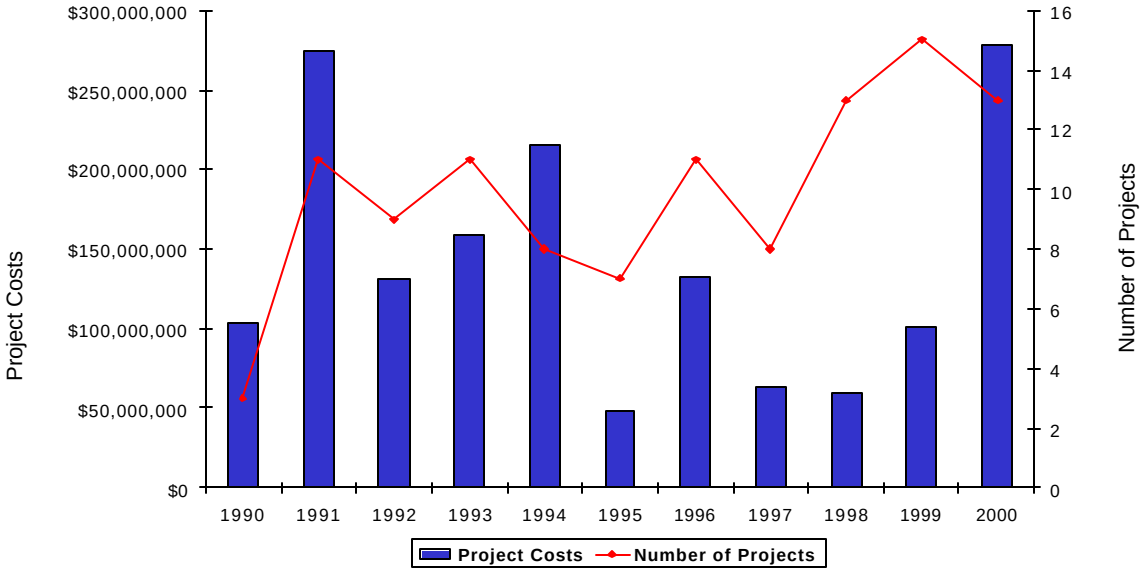
During 2000, the HSCRC completed a 15-month review of its entire rate setting system. This "system reinvention" was conducted to address the hospital industry's concerns about the complexity of the current system and to address the HSCRC's concerns with departmental unit rate control and charge per admission increases that the hospital industry was experiencing. In February of 2000, the HSCRC implemented a "charge per case" (CPC) targeting system for all hospitals. The basic premises of the CPC are: (1) inpatient rates are tied to a base year; (2) changes in case mix are provided for; (3) hospitals are given latitude in charging their departmental unit rates to allow achievement of their per case targets; (4) the system provides inflation for outpatient services; and (5), an annual update is provided to the CPC standard.

The HSCRC plays a pivotal role in the Commission's oversight of acute care hospitals under the Certificate of Need program. For all acute care hospital reviews conducted under the Certificate of Need program, the Commission consults with HSCRC concerning the financial feasibility of the proposed project. Under a 1988 change to the health planning law, hospital capital projects do not require CON review if the hospital assures HSCRC that the debt service of the project will not raise rates more than $1.5 million (the "Pledge"). Between January 1990-June 2001, the Commission has issued Determinations of Non-Coverage for 118 capital expenditure projects costing a total of $1.6 billion where hospitals have pledged not to increase rates more than $1.5 million (Refer to Figure 3). A description of the projects receiving Determinations of Non-Coverage from the Commission with a "pledge" not to increase rates is provided in the Appendix to the working paper. The Appendix also provides

[6] This transfer was affected by Chapters 11 and 112, Acts of 1998.

a list of Determinations of Non-Coverage for hospital capital projects below the threshold of $1.45 million.

Figure 3
Non-CON Hospital Capital Projects with Pledge Not to Increase Rates > $1.5 Million: Maryland, 1990-2000



Source: Maryland Health Care Commission

F. Maryland Health Care Commission (MHCC)

Through the health planning statute, the Maryland Health Care Commission is responsible for the administration of the State Health Plan, which guides decision making under the Certificate of Need program and the formulation of key health care policies, and the administration of the Certificate of Need program, under which actions by certain health care facilities and services are subject to Commission review and approval. Through the Certificate of Need program, the Commission regulates market entry and exit by the health care facilities and individual medical services covered by CON review requirements, as well as other actions the regulated providers may propose, such as increases in bed or service capacity, capital expenditures, or expansion into new service areas.

Certificate of Need as a regulatory tool has three levels, each initiated by a written notice or letter of intent to the Commission. For confirmation that a Certificate of Need is not required to establish a certain kind of health care facility or service, a party may request a "determination of coverage" by CON requirements. Staff and counsel analyze the proposal according to the Commission's statute and applicable regulations, and, if CON review and approval is not needed to undertake the project, the Executive Director issues a determination to that effect as the Commission's designee.

Proposed new health care facilities and specified actions by existing facilities that do require CON approval come to the Commission either in response to a schedule regularly published in the *Maryland Register*, or, if no schedule has been published for a particular

service, as an unscheduled review. Procedural rules dictate how unscheduled reviews must be handled so as to permit a comparative review. The CON review itself proceeds according to rules set forth at COMAR 10.24.01. In a CON review, the Commission evaluates an application against all applicable standards and need projections for the service in the State Health Plan, and applies six general review criteria related to the need for and the likely impact of the proposed project on the health care system. Statute requires that staff (or a Commissioner appointed as a reviewer in a comparative or competitive review) bring a recommendation on a proposed project to the full Commission within 90 days of docketing.[7] The first thirty days after docketing are set aside as a public comment period, in which interested persons may comment on the proposal or, if they meet criteria for interested parties in regulation, enter the review in opposition to the project.

Since 1985, the health planning statute has permitted the Commission to find, "in its sole discretion," that certain actions by existing health care facilities -- if the facilities proposing them are merging, or have merged and are proposing to further consolidate or to reconfigure their bed capacity or services – may be exempted from the Certificate of Need requirement that would otherwise apply. This exemption from the CON requirement may be granted through action by the Commission for several kinds of actions proposed "pursuant to a consolidation or merger" of two or more health care facilities, if the proposed action:

- Is "not inconsistent with" the State Health Plan;
- "Will result in the delivery of more efficient and effective health care services"; and
- Is "in the public interest."[8]

A merged asset system seeking such a finding by the Commission must provide notice of its intent at least 45 days before it requests action on the proposal. Additional procedural regulations (at COMAR 10.24.01.04C) require the Commission to provide notice to the public, with the opportunity to comment on the proposed action.

[7] Docketing is the formal start of a CON review; the time period in which a recommendation is to come to the full Commission is 150 days, if an evidentiary hearing is held. However, 1995 legislation to streamline the CON review process mandated the adoption of regulations that restrict evidentiary hearing to those cases in which the "magnitude of the impact" of a potential new facility or service merit the additional time and transactional cost.
[8] Health-General §19-123(j).

Market Entry

Entry into the market for proposed new medical-surgical and pediatric facilities or bed capacity has been explicitly regulated through Certificate of Need since the 1988 enactment of a list of "medical services" subject to CON if established by an otherwise-regulated health care facility.[9] As with all Certificate of Need review in Maryland, the analysis of an application for CON approval for a new facility or expanded bed capacity evaluates how a proposed project meet the applicable standards and policies in the State Health Plan, and how it addresses the six general review criteria found in the Certificate of Need procedural regulations at COMAR 10.24.01.07.[10]

The State Health Plan rules and standards that are applied to CON reviews of proposed new facilities or expansions fall into several distinct categories, including:

- **Docketing standards**, which determine whether applications for new facilities or expansions will be accepted and may be docketed for review;
- **Review standards**, which are applied to all applications, and provide a composite description of what the Commission has established -- through its staff research, deliberation, and the public adoption process – should characterize a facility or service of the kind under review;
- **Approval rules**, which set threshold standards that must be met, or a proposed project may not be recommended for Commission approval; and
- **Modification rules,** which guide the review of certain kinds of changes proposed to projects already granted Certificate of Need approval.

As noted earlier, the passage of HB 994 in 1999 altered Commission statute related to the closure of hospitals and medical services, and to other changes to bed capacity and services. As a consequence, both the applicability of these State Health Plan rules to hospital proposals and the Commission's authority to review and approve these proposals has also changed.[11] Table 11 presents a conceptual summary of the impact of these statutory changes on the applicability of CON review to the range of actions hospitals may propose. These rules and procedural steps are admittedly complex – a CON requirement that applies generally to hospitals is frequently waived if the facility belongs to a system, or is located in one of four Maryland jurisdictions with three or more hospitals. In fact, these rules and policies give a significant degree of regulatory flexibility to Maryland's hospital industry.

[9] Health-General §19-123 (a).

[10] In brief, these criteria require an application to: (1) address the State Health Plan standards applicable to the proposed project; (2) demonstrate need for the proposed new facility or service; (3) demonstrate that the project represents the most cost-effective alternative for meeting the identified need; (4) demonstrate the viability of the project by documenting both financial and non-financial resources sufficient to initiate and sustain the service; (5) demonstrate the applicant's compliance with the terms and conditions of any previous CONs; and (6) "provide information and analysis" on the "impact of the proposed project on existing health care providers in the service area."

[11] The Commission will issue a separate working paper analyzing policy options for applying the 140 percent rule with respect to changes in hospital beds and services.

Table 11
Conceptual Overview of Current Certificate of Need Regulation of Hospital Projects

	Action	Hospital Location/Organization			
		All Hospitals	**Hospitals In Counties With 3 or More Hospitals**	**Hospitals In Counties With 1 or 2 Hospitals**	**Hospitals In Merged Asset Systems**
New Facility or Service	New hospital facility	Certificate of Need			
	New medical service at hospital	Certificate of Need			CON exemption to reallocate system services among members, if not inconsistent with SHP, efficient and effective, and in public interest
	New specialized hospital service	Certificate of Need			
Bed Increases or Decreases	Bed increases or decreases among existing medical services at a hospital	Permitted yearly without CON since 1988 (now requested at time of annual "140%" re-licensure*)			
	Bed increases or decreases between members of merged system		Notice letter (45 days), only between system members and within same health service area*	CON Exemption	Notice letter (45 days); may not move system services outside county with notice letter only*
Capital Projects	Capital project under CON review threshold, or over threshold, with "pledge" not to raise rates > $1.5 million	Letter of determination that no CON required			
	Capital project over threshold (no "pledge") for new construction or renovation at existing hospital	Certificate of Need			
	Capital project over threshold (no "pledge"), to replace hospital on same/adjacent site	Certificate of Need			
	Capital project over threshold (no "pledge"), to relocate and re-build hospital on new site	CON for Capital Project			CON exemption if relocation outside primary service area, or notice letter if relocated within primary service area*
Hospital Closure	Conversion to limited service hospital	CON Exemption			
	Closure of hospital "or part of a hospital" (service or unit) **		Notice letter (45 days); hospital holds public hearing; includes State hospitals*	Notice letter (45 days); hospital holds public hearing; CON exemption	

*Change to statute enacted in 1999 by HB 994

**The requirements governing closure of a hospital apply to merged asset systems, as well as to independent hospitals.

Source: Maryland Health Care Commission (Note: For detailed information on CON requirements, refer to Health –General §19-114 - §19-130 and COMAR 10.24.01.)

Market Exit

HB 994 and its changes to Certificate of Need law applicable to "the closure of a hospital or part of a hospital" significantly altered the Commission's oversight authority with regard to potential closures of hospitals or their inpatient services, and with regard to the bed capacity of individual medical services. The Certificate of Need procedural rules applicable to hospitals in jurisdictions with three or more hospitals at Health-General Article §19-123 (l), allow hospitals to close without action by the Commission, provided that the Commission has received written notification 45 days before the planned closure, and the hospital has held a public informational hearing in the area affected by the closure.

IV. MARYLAND CERTIFICATE OF NEED REGULATION OF ACUTE CARE HOSPITAL SERVICES COMPARED TO OTHER STATES

On an annual basis, the American Health Planning Association (AHPA) publishes survey information, reflecting data it collects from state CON programs. Maryland is one of 36 states, plus the District of Columbia, that maintains a Certificate of Need program for reviewing certain types of new or expanded health care facilities and services. According to the 2001 version of the survey, 27 of the 37 programs regulate medical-surgical and pediatric services through CON review. In Maryland, the hospital capital expenditure review threshold indexed for inflation is now $1.45 million. Data from AHPA indicate that 22 states, including Maryland, have capital review thresholds for acute care hospitals between $1.0-$2.0 million. A small number of states have capital expenditure thresholds above $2.0 million.

In order to obtain current information as to how participating programs regulate medical/surgical and pediatric services through CON review, Commission Staff utilized the AHPA's electronic bulletin board service regarding state CON and other major health regulatory programs. Seven of the 37 programs responded to Staff's electronic inquiry.

The state of Illinois regulates acute care services in hospitals, but only for certain services. These services include medical/surgical, pediatrics, obstetrics, intensive care, rehabilitation, acute mental illness, neonatal intensive care, burn treatment, therapeutic radiology, open-heart surgery, cardiac catheterization, renal dialysis, PET scanning, and organ transplants.[12]

New Jersey no longer requires CON review for a hospital to add medical/surgical, obstetric, general pediatric, and adult ICU/CCU beds. However, all of the items removed from CON require compliance with licensure standards. New Jersey does require CON for psychiatric beds, pediatric ICU, neonatal intensive and intermediate care bassinets, burn care beds, comprehensive rehabilitation, and various services such as cardiac surgery and transplantation.[13]

Alaska requires a CON for acute care changes and it does not anticipate any modifications in the law during 2001. Currently, however, Alaska is writing new regulations, and will be developing standards in connection with medical/surgical and pediatric services.[14] Likewise, Virginia has not deregulated any hospital capacity or hospital-based services recently and is not planning to deregulate medical/surgical and pediatric services in the future.[15] Kentucky requires a CON to add or establish acute care beds.[16]

Rhode Island requires a CON for the following: (1) the establishment of a new service whose first full year of operating expenses will exceed $750,000, (2) for additional licensed beds, and (3) for capital expenditures exceeding $2 million. Rhode Island recognizes "unified plans", so hospitals cannot separate projects in order to fall below the $2 million threshold. A

[12] Electronic mail communication from Don Jones, Illinois CON program.
[13] Electronic mail communication from John Calabria, New Jersey CON program.
[14] Electronic mail communication from David Pierce, Alaska CON program.
[15] Electronic mail communication from Dean Montgomery, Director of Health Systems Agency of Northern Virginia.
[16] Electronic mail communication from Jayne Arnold, Kentucky CON program.

CON is required for the establishment of certain tertiary or specialty care services, such as PET, linear accelerator, cardiac cath/angioplasty/surgery, regardless of capital cost or operating expense.[17]

Effective January 1, 2002, Missouri will no longer require CON review regarding expanded, renovated, or modernized acute hospitals. However, Missouri will continue to require a CON regarding new hospitals (licensed hospitals that were not previously licensed at a specific location.)[18]

[17] Electronic mail communication from Michael Dexter, Rhode Island CON program.
[18] Electronic mail communication from Steve Feldman, Missouri CON program.

V. ALTERNATIVE REGULATORY STRATEGIES: AN EXAMINATION OF CERTIFICATE OF NEED POLICY OPTIONS

The options discussed in this section represent alternative regulatory strategies to achieve the goals and objectives embodied in Maryland's Certificate of Need program. In these options, the role of government varies on a continuum from expanded oversight to an extremely limited role. The options below, singly or in combination, suggest alternative strategies that could be considered in the context of the larger issue of the regulation of health care services in Maryland. This is not an exhaustive list of options. The Commission expects other options and ideas to be generated through the public comment process. The questions suggested in the guiding principles in the Commission's *An Analysis and Evaluation of Certificate of Need Regulation in Maryland: Study Overview* provide a framework for the evaluation of these options.

A. Acute General Hospital (Inpatient Medical-Surgical Services)

1. Option 1 – Maintain Existing Certificate of Need Program Regulation

This option would maintain the Certificate of Need program as currently applied to acute general hospitals. Under current health planning law, a Certificate of Need is required to develop a new acute care hospital facility. For existing acute care hospitals, a Certificate of Need would not be required for capital projects involving new construction or renovation over the review threshold (currently $1.45 million) provided that the hospital agrees not to increase patient charges or rates more than $1.5 million over the entire period or schedule of debt service associated with the project. The Commission makes this determination after consultation with the Health Services Cost Review Commission. For capital projects over the review threshold at an existing hospital, a Certificate of Need would be required if the hospital plans to seek a rate increase or desires to preserve the option to seek a future rate increase.

This option continues to promote the General Assembly's incentives for hospital closures by requiring only a 45-day notice to the Commission in jurisdictions with three of more hospitals. For acute care hospitals in jurisdictions with fewer than 3 hospitals, an exemption finding by the Commission would be required under current policy. Regarding hospital closures and the stricter exemption process for closures in one- and two-hospital jurisdictions than for multi-hospital jurisdictions, this option assumes that the benefits of closing a hospital in multiple-hospital jurisdictions outweighs the impact of reduced access in areas of possible excess capacity.

2. Option 2 – Expand Certificate of Need Program Regulation for Acute Care Hospital Closures

Under current health planning law, the closure of an acute care hospital requires either a 45-day notice or an exemption from CON review. Upgrading the Commission's role in the approval of an acute care hospital closures is a second alternative regulatory strategy. A finding by the Commission that exempts a proposed hospital closure from CON review is currently needed in jurisdictions with one or two hospitals; only notice to the Commission and a public hearing is necessary for a hospital closure in a multiple hospital jurisdiction. Option

2 would strengthen current oversight of closures by requiring hospitals in jurisdictions with three or more hospitals to obtain an exemption from the Commission to exit the market.

This option supports placing more public policy emphasis on ensuring geographic access to hospital services, particularly for vulnerable populations. Requiring the same level of review for multiple hospital jurisdictions as for one- or two-hospital jurisdictions would allow public review and community input into the potential impacts and solutions for the closure of an acute care hospital in all the areas of the state. On the other hand, this option modifies previous efforts at CON liberalization by re-imposing some level of review (i.e., exemption) that was previously eliminated from statute.

3. Option 3 –Expand Certificate of Need Program Regulation for Major Hospital Capital Projects by Eliminating the "Pledge"

Under current health planning law, acute care hospitals are not required to obtain a Certificate of Need for capital projects involving new construction or renovation over the review threshold (currently $1.45 million) provided that the hospital agrees not to increase patient charges or rates more than $1.5 million. Option 3 would expand Certificate of Need oversight of hospital capital projects by requiring Commission review and approval of all capital projects over the threshold.

4. Option 4 – Modify Certificate of Need Review by Eliminating or Reducing the Flexibility Provided to Merged Hospital Systems

Maryland state health policy favors hospital mergers in two ways. First, Health-General Article §19-123 provides incentives that exempt certain types of otherwise reviewable projects from the requirement to obtain a CON, if those actions are pursuant to a merger or consolidation. Second, Health-General Article §19-130 of the health planning statute expresses legislative intent to replace competition with regulation. When the Commission actually oversees hospital mergers and consolidations under section §19-130, the merging hospitals have federal and state antitrust immunity. Under Option 4, health planning law would be modified to eliminate the flexibility now provided to merged hospital systems to reconfigure beds or services or undertake major capital expenditures. Currently, merged hospital systems may be granted exemptions from CON review for projects pursuant to a consolidation or merger if three statutory criteria are met. These criteria require that the proposed change is not inconsistent with the State Health Plan, is efficient and effective, and is in the public interest.

This option would support the view that all hospital projects, regardless of whether undertaken by a merged asset system or an unaffiliated hospital, should be subject to the level of scrutiny provided by the Certificate of Need process. Alternatively, the flexibility now given to merged asset systems, which makes an already merged system and newly merged system eligible for the same exemptions, could be subject to a time limit. In this manner, changes in beds or services proposed by a hospital system would not be considered as pursuant to the past merger if they occurred beyond a specified time period (e.g., 5 years, 10 years). On the other hand, it could be argued that the incentives provided to merged asset systems have benefited the health care system by encouraging the voluntary reduction of excess hospital capacity and should be maintained in the future to promote the rationale development of needed acute care services.

5. Option 5 – Reduce Certificate of Need Review by Increasing the Capital Review Threshold to $2.5 Million

Another option is to reduce oversight of acute care hospital capital expenditures by increasing the capital expenditure threshold. Current law sets the capital expenditure threshold at $1,250,000, which indexed for inflation is now $1,450,000. Under this option, the capital expenditure threshold would be increased to $2,500,000. Increasing the capital review threshold could be considered in conjunction with the current policy of not requiring a Certificate of Need for projects that do not increase hospital rates by more than $1.5 million. Alternatively, the capital review threshold could be increased in conjunction with requiring Commission approval of all hospital capital projects.

Analysis of determinations of non-coverage issued by the Commission between January 1990-June 2001 for projects over the threshold indicates that 21 of the 118 projects were below $2.5 million; 52 projects were below $5.0 million. It could be argued that setting a higher capital review threshold would appropriately focus attention on larger projects with greater future impact on the health care system. On the other hand, the current review threshold, indexed for inflation, can be viewed as reasonable when compared with other state Certificate of Need programs and should not be modified given concerns about future system capacity.

6. Option 6 - Deregulation with Creation of Data Collection and Reporting Model to Assure Quality

Replacing the CON program's requirements governing market entry and exit with a program of mandatory data collection and reporting is another option for regulating acute care hospitals. Option 5 supports the role of government to collect and disseminate information in order to promote quality health services. Performance reports, or "report cards" are intended to incorporate information about quality into decisions made by both employers and employees in their choice of health plans, and by consumers whose health plans permit a measure of choice in providers. Performance reports can also serve as benchmarks against which providers can measure themselves, and seek to improve quality in any areas found deficient. As such, report cards may both inform consumer choice and may improve the performance of health services. Report cards for acute care hospital services could be implemented in at least two ways: public report cards designed for consumers, or performance reports designed to provide outcomes information and best practice models for providers.

♦ 6A - Public Report Card for Consumers

This option calls for the Commission to create a vehicle for public reporting of basic service-specific information in a report card style format, promoting consumer education and choice. Hospital report cards could be designed to report on facilities, physicians or provider groups, or a combination. In response to a 1999 legislative mandate, the development and implementation of hospital and ambulatory surgery facility report cards, similar to the HMO report cards currently produced by the Commission, is now underway. Therefore, this option could be considered a component of the planning for hospital report cards.

♦ 6B - Provider Feedback Performance Reports

Under this option the Commission, or another public or contracted private agency, would establish a data collection and feedback system designed for use by providers. Like the report card option, this involves mandatory collection of detailed outcomes and process information from all hospitals to measure and monitor the quality of care using a defined set of quality measures. The purpose would be to provide feedback on how hospitals and/or providers compare to their peers on relevant issues. This option is consistent with the recent national policy debate regarding the need for more information and improved accountability for outcomes. While CON is not intended to monitor quality after an approved program begins operation, this option does further that objective.

7. Option 7 – Deregulation with Creation of Licensure Standards

Under this option, the role of government oversight would shift from regulating market entry and exit to monitoring the on-going performance of the service through the development of enhanced licensure standards. Currently, acute care hospitals are licensed in Maryland based on compliance with standards developed by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). The licensure standards developed under this option could reflect, in addition to compliance with JCAHO standards, compliance with Maryland-specific standards. This option would require the development of State service-specific standards for licensing an acute care hospital. Currently, the OHCQ licenses the entire acute care hospital, and not individual services. Under the licensure model, non-compliance with standards may result in the loss of the license by the entire hospital or for a specific service offered by the hospital.

This option, similar to other options that remove barriers to market entry and/or exit, may potentially result in the development of additional acute care hospitals. On the other hand, under this option there would be greater public policy emphasis placed on performance goals. While the CON process provides a tool for examining quality issues before a provider enters the market, it is not now designed to monitor outcomes on an on-going basis.

8. Option 8 – Deregulation of Acute Care Hospitals from Certificate of Need Review

This option would remove Certificate of Need review and approval as a barrier to market entry and exit for acute care hospitals. Under this option, the Commission would defer its oversight authority to other agencies of State government, including the Office of Health Care Quality, MIEMSS, and the Health Services Cost Review Commission (HSCRC). The financial viability of acute care hospitals would continue to be regulated by the HSCRC. The removal of restrictions on market entry proposed under Option 8 could be combined with a moratorium on the future development of new or expanded acute care hospitals. While it is not clear that the overall supply of acute care hospitals would increase under a deregulation scenario, the experience in other states suggests that there would be potential interest in developing specialty hospitals (e.g., cardiac hospitals). It may also result in proposals to relocate acute care hospitals from city and inner beltway areas of the state to growing suburban regions.

B. Pediatric Services

1. Option 1 – Maintain Existing Certificate of Need Program Regulation

This option would maintain the Certificate of Need program as currently designed. Under current law, a CON is required to establish a new pediatric service in a hospital that is not a member of a merged asset system reconfiguring services. Pursuant to the passage of HB 994 in 1999, with a 45-day notice to the Commission, a merged asset, multi-hospital system may reconfigure pediatric service beds from one member hospital with a pediatric service to another member hospital that may not have a pediatric service, provided both hospitals are located in the same jurisdiction having three or more hospitals.

Reconfiguring a system's service capacity between facilities across county lines, on the other hand, may not be accomplished through a written notice, but requires that the Commission grant an exemption from Certificate of Need review. Since 1985, the Commission has had statutory authority to approve such exemptions to change the "type or scope of any health care service" offered by a health care facility (or facilities) that are part of a merged asset system, if the Commission finds, "in its sole discretion," that the proposed reconfiguration of beds or services is "not inconsistent with the State Health Plan," will result in the more efficient and effective delivery of health care services, and is in the public interest."[19] Although merged asset systems are permitted to seek CON exemption for the relocation of services between member hospitals, establishing a new pediatric service through relocation of beds across county lines is currently precluded by the policy assumptions of the bed need projection methodology in the State Health Plan and the projections of excess pediatric bed capacity.

As will be discussed under Option 2, Certificate of Need approval is not required to close a pediatric service in an acute general hospital; depending on the number of hospitals in the jurisdiction, this may be accomplished by either a 45-day written notice, or an exemption from CON review by the Commission. This option continues to promote the General Assembly's incentives for hospital mergers by allowing merged asset systems the flexibility to reconfigure services, under certain circumstances, without the requirement to obtain a CON. Regarding service closures and the stricter exemption process for closures in one- and two-hospital jurisdictions than for multi-hospital jurisdictions, this option also assumes that the benefits of closing a service in multiple-hospital jurisdictions outweigh the impact of reduced access in areas of possible excess capacity.

2. Option 2 – Expand Certificate of Need Program Regulation for Pediatric Service Closures

Under current health planning law, the closure of a pediatric service requires either a 45-day notice or an exemption from CON review. Upgrading the Commission's role in prior approval of pediatric service closures is an alternative regulatory strategy. A finding by the Commission that exempts a proposed hospital service closure from CON review is currently needed in jurisdictions with one or two hospitals; only notice to the Commission and a public hearing is necessary for a service closure in a multiple hospital jurisdiction. Option 2 would

[19] Health-General Article §19-123(j)(2)(iv), Annotated Code of Maryland.

strengthen current oversight of pediatric service closures by requiring hospitals in multiple hospital jurisdictions to obtain an exemption to exit the market.

This option supports placing more public policy emphasis on ensuring geographic access to pediatric services, particularly for vulnerable populations. The current CON rules allow hospitals in multiple hospital jurisdictions, including Baltimore City, to close without government oversight. Requiring the same level of review for multiple hospital jurisdictions as now exists in one- or two-hospital jurisdictions would allow public review and community input into the potential impacts and solutions to the closure of a pediatrics unit in all the areas of the state. On the other hand, this option re-imposes a level of review (i.e., exemption) that was previously eliminated from statute.

3. Option 3 – Maintain Existing Certificate of Need Program Regulation, With Regional Need Projection

This option involves changing the policies in the bed need projection methodology to project need for pediatric services on a regional rather than a jurisdictional basis. Currently the SHP projects need for pediatric beds on a jurisdictional (county) basis, and CON applications are reviewed against the standards and policies in the SHP. A merged asset system may currently, through only a notification letter, move beds between hospitals in the same *jurisdiction,* because the total number of beds in the jurisdiction does not increase. But moving beds to a member hospital in another jurisdiction would change the number of beds in two jurisdictions, and is precluded as long as the SHP projects excess capacity, and as long as pediatrics is regulated at the county level. If the need projections were instead to be developed on a regional basis, beds could be reallocated among the members of a merged asset system in the same *region* without changing the number of beds in the planning area. Because a provision added to the statute by HB 994 (1999) prohibits establishing a new service by moving beds across county lines, this option requires both a statutory and a regulatory change.

4. Option 4 – Modified Certificate of Need Oversight

Another option is to modify the standards under which proposals to establish new pediatric programs are reviewed, while retaining Commission authority to establish standards for access, quality, and cost effectiveness. This option, similar to the recommendation adopted by the Commission for acute inpatient obstetrics services, would change the State Health Plan to remove the threshold need requirement. This change would make it possible for the Commission to consider the merits of a Certificate of Need application for a new pediatric service. Currently, the policies in the State Health Plan permit the Commission to consider a CON application for a new pediatric service only if the need projection methodology identifies a need for additional bed capacity.

Like obstetrics, it could be argued that a pediatric service is a basic acute care hospital service, that only a small number of hospitals would potentially be interested in developing a new pediatric service, and that there may be merit to considering the benefits of proposals to establish new units. On the other hand, given the trend toward outpatient care for the vast majority of pediatric cases, the remaining inpatient services may become more and not less specialized in the future. From a public policy perspective, this scenario suggests little or no benefit to considering new programs given the need to ensure adequate caseloads and the effective use of limited nursing personnel.

5. Option 5 - Deregulation with Creation of a Data Collection and Reporting Model to Assure Quality

Another option for pediatric service regulation involves replacing the CON program's requirements governing market entry and exit with a program of mandatory data collection and reporting. This option, which is discussed in detail under the alternative regulatory strategies for acute care hospitals, supports the role of government to provide information in order to promote quality health services. As noted in the earlier discussion, the development and implementation of hospital and ambulatory surgery facility report cards, similar to the HMO report cards currently produced by the Commission, is now underway. Therefore, as noted earlier, this option could be considered a component of the overall planning for hospital report cards.

6. Option 6 – Deregulation with Creation of Licensure Standards

Under Option 6, the role of government oversight would shift from regulating market entry and exit to monitoring the on-going performance of the pediatric service through the development of licensure standards. Currently, acute care hospitals are licensed in Maryland based on compliance with standards developed by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). The licensure standards developed under this option could reflect, in addition to compliance with JCAHO standards, compliance with Maryland-specific standards based on the work of the DHMH Perinatal Clinical Advisory Committee and the American Academy of Pediatrics. Currently, the OHCQ licenses the entire acute care hospital, and not individual services. Under the enhanced licensure model, non-compliance with standards for the pediatrics service may result in the loss of the license for that service.

This option, similar to other options that remove barriers to market entry and/or exit, may result in hospitals without a pediatric service seeking to establish a service. On the other hand, under this option there would be greater public policy emphasis placed on performance goals. While the CON process provides a tool for examining quality issues before a provider enters the market, it is not now designed to monitor outcomes on an on-going basis.

7. Option 7 – Deregulation of Pediatric Services from Certificate of Need Review

Certificate of Need review and approval would be removed as a barrier to market entry and exit for pediatric services in acute care hospitals. Under this option, the Commission would defer its oversight authority to other agencies of State government, including the Office of Health Care Quality, MIEMSS, and the Health Services Cost Review Commission (HSCRC). The removal of restrictions on market entry proposed under this option could be combined with a moratorium on the future development of new pediatric services.

V. SUMMARY

This working paper examines the current policy and regulatory issues affecting acute care hospitals and pediatric services, and outlines several alternative policy options for changes to CON regulation, and the potential implications of those changes. Tables 12-13 summarize the policy options discussed in this paper. It is the expectation of the Commission that the public comment process involved in evaluating the CON program will identify additional policy options and approaches that merit consideration.

Table 12
Summary of Regulatory Options: Acute Care Hospitals
(Medical-Surgical Services)

Options	Level of Government Oversight	Description	Administrative Tool
Option 1 Maintain Existing CON Regulation	No Change in Government Oversight	• Market Entry Regulated by CON • Market Exit Through Notice or Exemption	Commission Decision (Certificate of Need/Exemption/ Notice)
Option 2 Expand CON Regulation for Hospital Closures	Increase Government Oversight	• Market Entry Regulated by CON • Market Exit Through Exemption	Commission Decision (Certificate of Need/Exemption)
Option 3 Expand CON Regulation for Major Hospital Capital Projects by Eliminating the "Pledge"	Increase Government Oversight	• Market Entry Regulated by CON and Exemption • Review All Major Capital Projects • Market Exit Through Notice or Exemption	Commission Decision (Certificate of Need/Exemption/ Notice)
Option 4 Modify CON Regulation by Eliminating or Reducing Flexibility Provided to Merged Hospital Systems	Increase Government Oversight	• Market Entry Regulated by CON • Market Exit through Notice or Exemption	Commission Decision (Exemption/Notice)
Option 5 Reduce CON Regulation by Increasing Capital Review Threshold to $2.5 Million	Reduce Government Oversight	• Market Entry Regulated by CON • Market Exit through Notice or Exemption	Commission Decision (Exemption/Notice)
Option 6 Deregulation with Creation of Data Collection and Reporting Model	Change Government Oversight	• No Barrier to Market Entry or Exit	Performance Reports/Report Cards
Option 7 Deregulation with Creation of Licensure Standards	Change Government Oversight	• No Barrier to Market Entry • Market Exit Based on Non-Compliance with Licensure Standards	Licensure Standards
Option 8 Deregulation of Acute Care Hospitals from CON Review	Eliminate government oversight in favor of market focus	• No Barrier to Market Entry or Exit	None

Table 13
Summary of Regulatory Options: Pediatric Services

Options	Level of Government Oversight	Description	Administrative Tool
Option 1 Maintain Existing CON Regulation	No Change in Government Oversight	• Market Entry Regulated by CON • Market Exit Through Notice or Exemption	Commission Decision (Certificate of Need/Exemption/ Notice)
Option 2 Expand CON Regulation to Pediatric Service Closures	Increase Government Oversight	• Market Entry Regulated by CON • Market Exit Through Exemption	Commission Decision (Certificate of Need/Exemption)
Option 3 Maintain Existing CON Program, With Regional Need Projection	Change government Oversight	• Market Entry Regulated by CON and Exemption • Market Exit Through Notice or Exemption	Commission Decision (Certificate of Need/Exemption/ Notice)
Option 4 Modified CON Oversight	Reduce Government Oversight	• Market Entry and Market Exit CON or Exemption	Commission Decision (Certificate of Need/Exemption/Notice)
Option 5 Deregulation with Creation of Data Reporting Model	Change Government Oversight	• No Barrier to Market Entry or Exit	Performance Reports/Report Cards
Option 6 Deregulation with Creation of Licensure Standards	Change Government Oversight	• No Barrier to Market Entry • Market Exit Based on Non-Compliance with Licensure Standards	Licensure Standards
Option 7 Deregulation of Pediatric Services from CON Review	Eliminate government oversight in favor of market focus	• No Barrier to Market Entry or Exit	None

Appendix

Determinations of Non-Coverage for Hospital Capital Projects: January 1, 1990-June 30, 2001